

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	<u>Provide</u>	<u>Withhold</u>
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____
_____	_____	_____
_____	_____	_____
Other specific requests:		

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

This request is made, after careful reflection, while I am of sound mind.

Date _____, 200____ x _____

This document was signed in our presence, by the above-named _____ (NAME) who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed.

x _____
(Witness)

(Number and Street)

(City, State and Zip Code)

x _____
(Witness)

(Number and Street)

(City, State and Zip Code)